PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Hawaii Department of Human Services

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Center for Medicaid and State Operations

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Table of Contents

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Pharmacy Plus Application

The State of Hawaii, Department of Human Services proposes an 1115 Demonstration Proposal entitled Prescription Plus, which will extend pharmacy services and related medical management interventions to qualified individuals whose income is at or below 300 percent of the federal poverty level (FPL).

I. GENERAL DESCRIPTION

This demonstration will extend pharmacy coverage to individuals in a fashion that furthers public, private, and individual fiscal responsibility. The Department of Human Services, Med-QUEST Division, will administer the proposed demonstration program designed to assist low-income individuals without or with minimal prescription drug coverage such as Medicare beneficiaries who are age 65 or older or who have a disability to access lower cost prescription drugs. The demonstration offers assistance by providing access to and making more affordable prescription drugs. The demonstration program will only apply to the prescription drugs dispensed through retail pharmacies. Drugs provided through hospitals, long-term care facilities, home health agencies, or other healthcare providers will not be covered. The proposed program also assists in the management of the enrollee's pharmacy services. An important element in Pharmacy Plus is the use of competitive private sector approaches, such as benefit management, to provide more cost effective, modern prescription drug benefits to the expanded population.

Individuals eligible for the proposed program include those who have household incomes at or below 300% of the Federal Poverty Level (FPL), which may include Medicare beneficiaries, who have not been determined eligible for traditional Medicaid benefits, whether or not they are eligible for Medicare Savings programs under Medicaid (which pay Medicare premiums, and in some cases, Medicare cost sharing expenses, e.g., QMBs and SLMBs) and/or people with a disability. Cost sharing - in the form of copayments - for the expansion population will differ from cost-sharing requirements for the regular Medicaid program.

The budget neutrality ceiling will be a single aggregate budget amount for the demonstration period. The state will be accountable for both expenditure and enrollment growth in the population subject to the budget neutrality ceiling which includes the demonstration enrollees.

The demonstration will operate for 5 years, beginning approximately September 1, 2003.

II. ASSURANCES

Each of the following items are checked to indicate an assurance:

A. X **Primary care coordination**. The demonstration includes a mechanism to direct demonstration enrollees who access services to sources of primary health services. Such primary care will include, but is not limited to, medical management related to prescription and non-prescription pharmaceutical products. The state assures that those individuals who do not have access to primary care as Medicare beneficiaries will have access to primary care services. More information about this requirement is provided in Section IV, Part I.

B. X **Benefits, access to services, and cost sharing.** The benefits and rights of the State Plan eligibility groups, except for restriction to choice of providers as provided through a section 1115(a)(1) waiver of 1902(a)(23) through Pharmacy Plus, are as provided for in the state's Medicaid State Plan, Title 42 of the Code of Federal Regulations, and Title XIX of the Social Security Act.

C. X **Budget neutrality.** The waiver program is anticipated to increase access to benefits and reduce recipient drug costs without significant Federal funding. The benefits and rights of the State Plan eligibility groups are not altered by this demonstration. An Excel budget worksheet is provided that includes the budget projections, information about covered individuals, trend rate information, and a narrative description of the calculations. More information about this requirement is provided in Section VI.

D. X **Public notice requirements**. The demonstration complies with public notice requirements as published in the Federal Register, Vol. 59, No. 186 dated September 29, 1994 (Document number 94-23960) and Centers for Medicare & Medicaid Service (CMS) requirements regarding Native American Tribe consultation. Provide information about this assurance in Attachment 1.

III. STATE-ONLY FUNDED PHARMACY PROGRAMS

The following information is provided for current state-only funded pharmacy programs (Check all that apply):

A. _____ State Program Entirely Subsumed Into Demonstration. A state-only funded pharmacy program named _____ currently exists, and it will be subsumed by the demonstration (Complete this section for each state program that will be entirely subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

1. Income level ceiling. The income level ceiling for participation is_____ percent FPL.

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
    a. _____ age group (describe):
    c. _____ condition specifications (describe):
    d. _____ other specifications (describe):

3. Benefit coverage scope. The scope of benefits covered under the program is
    a. _____ broad (such as the Medicaid package)
    b. _____ narrow (such as limited to drugs to treat specific health conditions)
    c. _____ other (describe):

3. _____ There are enrollee financial contributions, which include:
    a. _____ premiums (describe):
    b. _____ deductibles (describe):
    c. _____ copayments/coinsurance (describe):
    d. _____ other (describe):

5. _____This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:
    a. _____expanding the scope of coverage (e.g., type or number of prescriptions available)
    b. _____expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
    c. _____expanding the type of individuals eligible
    d. _____expanding the number of individuals eligible
    e. _____expanding funding to assist with premiums and cost sharing
    f. _____other (describe)

6. Annual cost. Currently the program expenditures are $_____ on an annual basis for the program.

7. Enrollment figures. Currently there are _____ enrollees in the program.

B. ____ State Program Partially Subsumed Into Demonstration. A state-only funded pharmacy program named _____ currently exists, and will be **partially** subsumed by the demonstration (Complete this section for each state program that will be partially subsumed into the demonstration program. Provide as an attachment a description of the state-only funded program, including enrollee cost-sharing, benefit limits, wraparound coverage, and any other pertinent features).

1. Income level ceiling. The income level ceiling for participation is_____ percent FPL.

2. Program eligibility characteristics. In addition to income ceiling, the program eligibility parameters have the following further specifications:
    a. _____ age group (describe):
    b. _____ condition specifications (describe):
    c. _____ other specifications (describe):

3. Benefit coverage scope. The scope of benefits covered under the program is
    a. _____ broad (such as the Medicaid package)
    b. _____ narrow (such as limited to drugs to treat specific health conditions)
    c. _____ other (describe):

4. _____ There are enrollee financial contributions, which include:
    a. _____ premiums (describe):
    b. _____ deductibles (describe):
    c. _____ copayments/coinsurance (describe):
    d. _____ other (describe):

5. _____This proposed demonstration will be an expansion of coverage compared to the current state pharmacy program through:

    a. _____expanding the scope of coverage (e.g., type or number of prescriptions available)
    b. _____expanding the pharmacy services available (e.g., by providing a pharmacy or nurse consultant who will provide additional management services)
    c. _____expanding the type of individuals eligible
    d. _____expanding the number of individuals eligible
    e. _____expanding funding to assist with premiums and cost sharing
    f. _____other (describe)

6. Annual cost. Currently the program expenditures are $_____ on an annual basis for the program.

7. Enrollment figures. Currently there are _____ enrollees in the program.

C. **_____ State Program Not Subsumed by Demonstration.** A state-only funded pharmacy program(s) named _____ currently exists, will not be subsumed by the demonstration, and will continue to operate during the Pharmacy Plus demonstration operation.

D. **_X_ No State Funded Pharmacy Program Currently Exists.** A state-only funded pharmacy program does not exist in this state.

IV. PROGRAM ELEMENTS

Population to Whom Eligibility is Expanded under this Demonstration

Individuals eligible for Pharmacy Plus include qualified individuals with household incomes at or below 300% of the FPL.

A. Eligibility Groups

1. _____ Aged individuals (65 and older)
   a. ___ Medicare beneficiaries
   b. ___ non-Medicare beneficiaries
   c. ___ individuals with private pharmacy coverage (describe):
   d. _____ other (describe):

2. ____ Individuals with Disabilities (ages all)
   a. ___ Medicare beneficiaries
   e. ___ individuals with private pharmacy coverage (describe):
   b. ___ Social Security Disability Insurance (SSDI) beneficiaries in 24-month waiting period for Medicare
   c. ___ lost SSDI due to earnings (disabling condition continues)
   d. ___ could receive Supplemental Security Income if federal eligibility rules used (for 209(b) states)
   e. _____ other (describe):

3. _X__ Other (describe): Beneficiaries must meet the following requirement:
   - Family income less than or equal to 300% of the FPL

B. Income Groups

1. ___ percent of FPL is the ceiling for the demonstration expansion group for aged individuals. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid State Plan coverage percentage level for this group is 100 percent FPL (if group varies within the aged population, describe):

2. ___ percent of FPL is the ceiling for the demonstration expansion group for individuals with disabilities. NOTE, the CMS proposed ceiling is 200 percent FPL or below. The current Medicaid State Plan coverage percentage level for this group is 100 percent FPL (if group varies within the disabled population, describe):

3. X Other –300% FPL is the ceiling for all persons in the demonstration expansion group. Eligibility for participation in the demonstration is not limited to any "eligibility group", but instead, to those who meet the Medicaid basic eligibility requirements such as citizenship/qualified alien status, State residency, social security number, not residing in a public institution and the income criteria. Persons meeting the Medicaid basic eligibility requirements and whose countable family income does not exceed 300 percent of the

federal poverty levels for Hawaii for a family of appropriate size may participate in this demonstration.

The current Medicaid program is separated into two methods of providing services, the fee-for-service program and the managed care program. Generally, individuals who are 65 and over or certified blind or disabled are covered under the fee-for-service Medicaid Program. The managed care program has two components, QUEST and QUEST Net, which are both Section 1115 Demonstration Programs. For the QUEST program, the income limits for an individual or family are as follows:

- Pregnant women whose countable family income does not exceed 185% of FPL
- Children under age 19 whose countable family income does not exceed 200% of FPL
- All other individuals whose countable family income does not exceed 100% of FPL

For the QUEST Net program, an individual or family gross income cannot exceed 300% of the federal poverty level.

C. Income Adjustments

1. ___ Income is adjusted
   a. ___ in the same manner as in Medicaid for the _____ group
   b. _____ in a different manner than in Medicaid (describe):
2. __X__ income is not adjusted

D. Assets Test (an assets test of some level is recommended)

1. ____ an assets test will apply. It is
   a. _____ the same as the Medicaid assets test for the _____ group
   b. _____ different from the Medicaid assets test (describe)
2. _X__ no assets test will apply

E. Enrollment Limit

1. _____ is the total number of enrollees permitted to enroll in the demonstration (describe how and why this number was chosen): The state should clarify whether enrollment limits are year-specific or if the enrollment limit is the maximum enrollment for the five years. (For example, the state intends that 50,000 will enroll and the cap starts whenever 50,000 people enroll; or the state intends that 50,000 will enroll in Year One, 55,000 in Year Two, 60,000 in Year Three, etc.)
2. _X__ There will not be an enrollment ceiling
3. _____ The state will not utilize an enrollment ceiling initially, but will track budget neutrality and plans to utilize the enrollment ceiling at a later point in time (describe):

F. Pharmacy Benefits Package

Consistent with the pharmaceutical focus of Pharmacy Plus, the demonstration does **not** include non-pharmacy benefit changes (such as reducing Medicaid coverage for other services or reducing coverage for existing Medicaid populations). The challenge posed in Pharmacy Plus is to improve cost-effectiveness through maintaining the health status of individuals and managing medications more effectively. The drug rebate provisions of section 1927 of the Social Security Act are triggered by state payments for prescription drugs under the plan by operation of the Pharmacy Plus demonstration project, and thus, rebates may be collected from manufacturers for drugs provided to the expansion population.

The following describes the proposed benefits to be included in this demonstration (check all that apply):

1. _X_ demonstration eligibility will be extended to those who have pharmacy coverage through private health insurance, and enrollees will receive:
   a. _____ Assistance with private health insurance cost sharing (see Section V.H.):
   b. _____ wraparound services (See Section V.H.):
   c. _X__ other (describe and See Section V.H.): Recipients who have third party liability (TPL) will be allowed into the program, but the program will only pay for a prescription if the TPL does not cover the drug or the benefit under the TPL has been exhausted. Therefore if the recipient has a TPL, the program will not pay for the patient's co-payment for the prescription drug, which differs from the current Medicaid program.

2. _X_ enrollees without private health insurance pharmacy coverage will receive prescription drug coverage as follows:
   a. _____ the benefit package will be the same as in the Medicaid State Plan for non-demonstration enrollees
   b. _X_ the benefit package will differ from that in the Medicaid State Plan for non-demonstration enrollees in that:
      i. _____ certain classes of drugs will be excluded or limited (describe):
      ii. _____ the number or frequency of prescriptions covered will be less than in the Medicaid State Plan for non-demonstration enrollees (describe):
      iii. _____ drugs covered only for specified conditions (describe):
      iv. _X_ other (describe): Unlike the Medicaid program, demonstration program recipients will not be required to use generic drugs first. The demonstration will not cover out-of-state prescription fills. Additionally, only drugs dispensed through retail pharmacies will be covered.
   c. _____ other (describe):

3. the state limits benefits to a financial ceiling per _____ of $ _____ (describe):

4. _X_ other (describe): The recipient will pay the Medicaid price for the prescription drug plus the Medicaid dispensing fee ($4.67) less the State portion ($1.00).

G. Pharmacy Benefit Management

Pharmacy Plus programs may use private-sector benefit management approaches consistent with the requirements of section 1927(d) (such as pharmacy benefit managers, preferred drug lists, prior authorization, pharmacist consultation, provider education, disease state management, and variable enrollee cost sharing) in order to more efficiently and effectively manage pharmaceutical costs and ensure that spending stays within the federal budget neutrality cap. In accordance with 1927, these benefit management approaches may also be extended to some or all of the existing Medicaid population, and the resulting savings used to assist in achieving budget neutrality. The demonstration will include pharmacy benefit management as follows:

1. _X_ pharmacy benefit manager (describe):
   a. _X this is currently used in the state Medicaid program, will continue to be operated similarly, and it is currently under contract with Affiliated Computer Services (ACS).

      MQD will utilize its Pharmacy Benefit Manager (PBM) for the current Medicaid fee-for-service program to provide claims processing, drug utilization review, prior authorization review, and rebate management services to the expanded program recipients.

      The PBM will process claims through its system and perform the necessary eligibility checks and claim edits. For approved claims, the PBM will pay the pharmacy the State portion of $1.00 per prescription filled. The PBM will also provide a remittance advice to the pharmacy listing the claims that were approved and denied. On a weekly basis, the PBM will invoice MQD for the amount of the State portions paid to the pharmacies. On a monthly basis the PBM will submit an invoice to MQD for the administrative fee for its services and a paid claims file.

      The PBM will be responsible for managing the rebates from the drug manufacturers. They will invoice the manufacturers on a quarterly basis, receive the rebate moneys, reconcile the rebate moneys received from the manufacturers, and handle any disputes in the rebate amounts with the manufacturers. The PBM will provide the rebate monies, reconciling reports, and utilization information to MQD.

   b. ____this is not used in the Medicaid program and will be used only for demonstration enrollees.
   c. ____this will be introduced with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population.
   d. ____ other (describe):

2. _X_ prior authorization consistent with Section 1927(d)(5) (describe):

   a. _X__ this is currently used in the state Medicaid program

      This function will be handled by the PBM. The PBM will handle it in the same manner as they do for the current Medicaid fee-for-service program. The prior authorization process includes authorization of restricted drugs, authorization of drugs above MAC price, and authorization of special billings.

   b. _____ this is not used in the Medicaid program and will be used only for demonstration enrollees
   c. _____ this will be introduced as a State Plan Amendment with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population.

3. _____formulary or formulary exclusions consistent with Section 1927(d)(4) of the Social Security Act (describe):
   a. _____this is currently used in the state Medicaid program
   b. _____this is not used in the Medicaid program and will be used only for demonstration enrollees
   c. _____this will be introduced as a State Plan Amendment with the demonstration and will apply to both the demonstration and non-demonstration Medicaid population.
4. _____ other (describe)

H. Coordination with Other Sources of Pharmacy Coverage – Private, State, and Medicare Plus Choice Plans

Coordination with and non-duplication of existing sources of health insurance is an important feature of the Pharmacy Plus Demonstration. It maintains the position of Medicaid as payer of last resort and provides an incentive for enrollees to continue to participate in private coverage, thus supporting the maximization of participation in private insurance, employer sponsored insurance, COBRA, retiree health insurance plans, Medigap plans and Medicare+Choice plans. Pharmacy Plus is designed to work effectively with other Medicare pharmacy options.

The coordination and support can be:

- Payments made to private carriers or to enrollees made in lieu of direct coverage of pharmaceuticals under the Pharmacy Plus program; and/or
- In the form of providing wraparound pharmaceutical coverage to bring private sources of pharmacy coverage up to the level of the Pharmacy Plus benefit coverage.

In this demonstration, the following approaches will apply (check all items that apply – Also, See Section V.F.1.):

1. _____ Subsidies/cost sharing assistance for private health insurance coverage will be provided under the demonstration, and is clarified in the submitted budget neutrality information. The process for providing the subsidy will be described in the operational protocol and CMS approval of the payment methodology and amount will be requested. Subsidies/incentives will be provided for enrollees to maintain coverage of the following:

   a. _____ Private health insurance coverage (describe):
   b. _____ Medigap (describe):
   c. _____ Medicare-endorsed pharmacy discount cards. The demonstration includes financial contribution towards the drugs purchased using the card (describe coordination with the card and contribution to the purchase)
   d. _____ other (describe)

2. _____ Pharmacy coverage will be provided to enhance other sources of pharmacy coverage, such as state programs, Medicare+Choice and private sources of coverage in a wraparound fashion in order to encourage participation in existing public and private sources of care (describe):

3. _____ Other (describe):

4. _X_ Third Party Liability (TPL) will be collected in the demonstration in the following manner (describe): Applicants will be required to provide TPL information on the application form. TPL information will be updated at least once per year upon recertification. It will be the recipients' responsibility to provide updated TPL information if their coverage changes during the year.

5. _____ Third Party Liability will not be collected in the demonstration because

   a. _____ individuals with other pharmacy coverage are excluded
   b. _____ other (describe):

6. _____ Coordination with other sources of coverage is not part of this demonstration because: _____

I. Primary Care Coverage and Related Medical Management (check all that apply)

The demonstration includes a mechanism to ensure that demonstration enrollees have access to primary care health services that will assist with medical management related to pharmacy products prescribed. These aspects of the demonstration will be implemented as follows:

1. _X_ Demonstration enrollees who have a source of coverage for primary care (for

example, Medicare coverage) will use their primary care providers to coordinate the pharmacy benefit (describe):

Recipients will use their primary care providers to obtain prescriptions. These prescriptions can be filled at a retail pharmacy. If a recipient has TPL coverage that would cover the prescription drug and the benefit has not been exhausted, this program will not cover the drug, including any co-payment. Otherwise the recipient will be able to use his benefits under this program to fill his prescription at a participating Medicaid retail pharmacy.

2. _X__ Demonstration enrollees who do not have a source of primary care coverage will receive primary care services through the demonstration as follows:
   a. _____ A primary care benefit the same as that in Medicaid will be provided (describe):
   b. _____ A limited primary care benefit of _____ number of visits per _____,which entail the following services will be provided by _____ practitioners: _____.
   c. _X___ Primary care access will be ensured by connecting clients to primary care sources for care in the community (e.g., FQHCs/RHCs, Ryan White providers, Indian Health Services facilities, Veterans' Affairs clinics, etc.) If the above is checked, the following must be checked and completed:
      i. _X___ state to work with Primary Care Associations to facilitate access to services
      ii. _X___ geographic breakdown of FQHC services provided that demonstrates adequate capacity to serve the demonstration population
      iii. _X___ pharmacy and state written materials for demonstration participants include names, locations, and phone numbers of community sources of primary care
      iv. _____oral counseling by pharmacists to include information on accessing primary care
      v. _____ Other (describe)

3. _X___ Other (describe):

The functions performed by the PBM will assist with medical management and are already in place for the current Medicaid fee-for-service program. Prospective Drug Utilization Review (Pro-DUR) functions provided by the PBM Point of Sale (POS) system shall alert pharmacists when several defined conditions are present. These conditions will include but are not limited to, recognizing when a prescribed drug could cause an adverse reaction when taken in combination with other drugs prescribed for the same recipient. It will also include situations when a drug may be contra-indicated due to the presumed physical condition of the patient based on their drug history. Other areas addressed include early refills, excessive days supply and high doses. Pro-DUR will also be closely integrated with Retrospective Drug Utilization Review (Retro-DUR). Retro-DUR includes reviewing patient drug history profiles based on paid claims data for items such as

therapeutic appropriateness, over and under utilization, appropriate use of generic products, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage or duration of therapy, and clinical abuse or misuse.

J. Premiums and Cost Sharing Information (check all that apply)

Flexibility to include cost sharing, similar to that found in employer sponsored private health insurance coverage, is an important feature of the Pharmacy Plus Demonstration. Enrollee cost sharing can be in the form of annual or monthly premium assessments, per-prescription co-payment requirements, coinsurance, deductibles, and coverage limits. Cost sharing helps the state to operate a budget neutral program and encourages personal responsibility and involvement of enrollees in their health care. States may require that cost sharing be met by demonstration participants (i.e., those in the expansion population) in order to receive benefits under the program. Cost sharing may be used to reduce program costs by requiring enrollee payments. To encourage the use of generic drugs and to discourage the use of costly drugs for which there are lower cost alternatives, Pharmacy Plus encourages states to use a three-tier system of copayments. Cost sharing models used in Pharmacy Plus may be designed to protect people with most severe illnesses or disabilities by offering "stop-loss" protection against the cumulative impact of copayments and deductibles

1. _____ The proposed program will include enrollee cost sharing (enrollment fees, premiums, copayments, coinsurance, deductibles, etc.):

    a. _____ Enrollment fees will be required and are _____ every enrollment period of _____ months. If the fees vary according to individual FPL, specify below (describe):
    b. _____ Premiums will be required:
        i. ____ Premiums are tiered or charged according to a sliding fee schedule that is ____ attached or ____ described below:
        ii. ____ Premiums are fixed in the amount of $ _____ per person on a _____ monthly basis, _____ annual basis, or _____ other (described):

        iii. ____ Other (describe):
    c. _____ Copayments and Coinsurance:
        i. ____ three-tiered co-payment system (describe):
        i. in the amount of _____ per prescription or
        ii. ____ Beneficiaries will have different co-payments for single source, branded multi-source, and generic drugs, according to the following schedule (describe):
        iii. Brand name: $____ per prescription or ____ percent of the cost.
        iv. Branded multi-source: $____ per prescription or ____ percent of the cost.
        v. Generic: $____ per prescription or ____ percent of the cost.

    d. _____ Deductibles (describe):

e. _____ Cost sharing requirements will vary with utilization (i.e.,premiums, copayments, and coinsurance)
   i. _____ Cost sharing amounts/requirements will decrease as individuals use more services (describe):
   ii. _____ Cost sharing amounts/requirements will increase as individuals use more services (describe):
   iii. _____ Other (describe):

2. _____ The proposed program will not include enrollee cost sharing that differs from that in the Medicaid State Plan

3. _____ The proposed program will include enrollee cost sharing stop-loss protections (describe):

4. _X_ Other (describe): Recipients will pay for prescriptions at the Medicaid rate for the prescription drug plus the Medicaid dispensing fee ($4.67) less the State portion ($1.00).

K. The Demonstration Will Deliver Services in the Following Manner (check all that apply)

1. _____ Services will be delivered through private health insurance coverage

2. _X_ Services will be delivered fee-for-service through this demonstration

3. _____ Services will be delivered through a system other than fee-for-service through this demonstration (describe):

4. _X_ Services will be delivered through this demonstration using the same network of providers that deliver comparable services to Medicaid beneficiaries

5. _____ Services will be delivered through this demonstration using a subset of providers that deliver services to Medicaid beneficiaries

6. _____ Services will not be delivered by providers that serve Medicaid beneficiaries (describe how providers will be selected)

7. _____ Other (describe):

V. BUDGET NEUTRALITY

MQD anticipates that the waiver program will increase access to benefits and reduce recipient drug costs without significant incremental Federal and State funding. The majority of the benefit costs will be paid by the recipient including the Medicaid rate plus the dispensing fee less the State's contribution. In the first year of the program, the State will be contributing $1 for each prescription filled by a retail pharmacy. The State's contribution in the first year will be funded by the State legislature through appropriation to the DHS budget. In the remaining four years of the program, the State will be contributing $5 in year two, $7 in years three and four, and $8 in year five for each prescription filled by a retail pharmacy. The State's contribution will not be claimed for federal matching. The administrative costs will be funded through a combination of State appropriations, a portion of the drug manufacturers' rebates, federal matching, and interest payments. MQD will be requesting matching federal funds only for the administrative costs of the program. These costs will include the salaries and benefits for the FTEs who determine eligibility and enroll the recipients, claims adjudication costs, supplies, equipment, lease rental and other administrative costs.

The schedule on the following page shows the budget neutrality calculations for each fiscal year starting with demonstration start-up costs in FY 03 to the demonstration program for the five years from FY 04 to FY 08. The State fiscal year ends on June 30th.

A. Impacted Budget Neutrality Population. Table V.1 identifies the Medicaid population groups that are included in the budget neutrality calculation (i.e., the impacted population).

Table V.1 (check all groups that apply):

Population	All (1)	Institutionalized (2)	Community Dwelling (3)	Other (described): (4)
Aged				
Blind/Disabled Adults				
Blind/Disabled non-Adults				
Other				Individuals with family income at or below 300% FPL.

B. Costs. The state estimates the services cost of this program will be $0 over its 5 year demonstration period. The state estimates the administrative cost of this program will be $10,608,410 over its 5 year demonstration period.

Refer to the following schedule for details.

Summary by Fiscal Year

	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	Total
Inputs							
New recipients - initial start-up	-	130,000	24,000	-	-	-	
New recipients - ongoing growth	-	-	901	1,556	1,572	1,588	
Continuing recipients	-	-	130,000	154,901	156,457	158,028	
Recipients enrolled	-	130,000	154,901	156,457	158,028	159,616	
Recipients by age							
Under 65	-	123,630	147,310	148,790	150,285	151,794	
Over 65	-	6,370	7,591	7,667	7,744	7,822	
Prescriptions per recipient per month							
Utilization for recipients under 65	-	0.70	0.70	0.70	0.70	0.70	
Utilization for recipients over 65	-	1.59	1.59	1.59	1.59	1.59	
Number of prescriptions	-	574,521	1,338,521	1,385,452	1,399,370	1,413,428	6,111,292
Average prescription cost	-	$55	$55	$55	$55	$55	
Average drug rebate %	-	15%	15%	15%	15%	15%	
State contribution per prescription	-	$1.00	$5.00	$7.00	$7.00	$8.00	
PBM cost per claim adjudicated	-	$1.10	$1.10	$1.10	$1.10	$1.10	
Funding							
State Contribution - Admin	$1,500,000	$0	-$1,500,000	$0	$0	$0	$0
Federal Contribution - Admin	$283,213	$788,105	$1,055,726	$1,042,698	$1,058,894	$1,075,570	$5,304,205
Drug Rebates (6 month lag for receipt)	$0	$917,380	$9,192,930	$11,372,995	$11,487,248	$11,602,648	$44,573,200
Total Funding	**$1,783,213**	**$1,705,485**	**$8,748,655**	**$12,415,693**	**$12,546,141**	**$12,678,218**	**$49,877,405**
Expenditures							
Program Benefit							
State Contribution	$0	$574,521	$6,692,607	$9,698,164	$9,795,591	$11,307,425	$38,068,308
Total Benefit	**$0**	**$574,521**	**$6,692,607**	**$9,698,164**	**$9,795,591**	**$11,307,425**	**$38,068,308**
Program Administration							
Payroll							
6 Enrollment Clerks	$0	$157,500	$165,375	$173,644	$182,326	$191,442	$870,287
Supervisor	$0	$41,996	$44,096	$46,300	$48,615	$51,046	$232,053
Clerk Typist	$0	$18,900	$19,845	$20,837	$21,879	$22,973	$104,434
Total Salaries	**$0**	**$218,396**	**$229,316**	**$240,781**	**$252,820**	**$265,461**	**$1,206,775**
Fringe Benefit	$0	$70,367	$73,885	$77,580	$81,459	$85,532	$388,823
Total Payroll	**$0**	**$288,763**	**$303,201**	**$318,361**	**$334,279**	**$350,993**	**$1,595,597**
Other Current Expenditures							
Consulting/Programming	$450,000	$0	$0	$0	$0	$0	$450,000
Temp FTEs for start-up	$0	$394,240	$122,880	$30,720	$30,720	$30,720	$609,280
Telephone Installation	$11,000	$0	$0	$0	$0	$0	$11,000
Telephone Ongoing	$0	$7,260	$4,320	$3,240	$3,240	$3,240	$21,300
Lease Rental	$0	$155,100	$90,000	$90,000	$90,000	$90,000	$515,100
Desktop Computer	$55,800	$0	$0	$0	$0	$0	$55,800
Modular Furniture	$45,000	$0	$0	$0	$0	$0	$45,000
Supplies	$4,125	$1,375	$2,250	$1,500	$1,500	$1,500	$12,250
Postage	$0	$96,200	$114,626	$115,778	$116,941	$118,116	$561,661
ACS Claim Cost	$0	$631,973	$1,472,374	$1,523,997	$1,539,307	$1,554,771	$6,722,422
Fax	$500	$300	$600	$600	$600	$600	$3,200
Copier	$0	$1,000	$1,200	$1,200	$1,200	$1,200	$5,800
Total OCE	**$566,425**	**$1,287,448**	**$1,808,250**	**$1,767,035**	**$1,783,508**	**$1,800,147**	**$9,012,813**
Total Administration	**$566,425**	**$1,576,211**	**$2,111,451**	**$2,085,396**	**$2,117,787**	**$2,151,140**	**$10,608,410**
Total Expenditures	**$566,425**	**$2,150,731**	**$8,804,058**	**$11,783,560**	**$11,913,378**	**$13,458,565**	**$48,676,718**
Revenue Over Expenditures	**$1,216,788**	**-$445,246**	**-$55,403**	**$632,133**	**$632,763**	**-$780,347**	**$1,200,688**
Cumulative Revenue Over Expenditures	**$1,216,788**	**$771,541**	**$716,139**	**$1,348,272**	**$1,981,035**	**$1,200,688**	

The following is a description of the items on the schedule and the related assumptions used.

Item	Description
New recipients - initial start-up	New recipients during program start up. Based on calculations from government census data and legislative testimony.
New recipients - ongoing growth	Once the program is established, these are the incremental new recipients each year. Used 1% increase in population per year based on Hawaii Department of Business Economic Development and Tourism grown projections.
Continuing recipients	Recipients continuing their eligibility for the 12 month period.
Recipients by Age: • Under 65 • Over 65	Recipients by age based on the percentage for the overall demonstration population within each age group.
Utilization for recipients under 65	Average prescriptions dispensed per month for recipients under the age of 65. Based on current usage for Medicaid FFS program and non-Medicare usage for HMO members.
Utilization for recipients over 65	Average prescriptions dispensed per month for recipients over the age of 65. Based on usage for Medicare HMO members.
Number of prescriptions	Number of prescriptions dispensed for all recipients.
Average prescription cost	Average prescription cost based on current Medicaid FFS program.
Average drug rebate %	Rebate percentage from drug manufacturers currently participating in the Medicaid program. Percentage also accounts for any amounts in dispute with the drug manufacturers.
State contribution per prescription	State contribution per prescription set by the 2002 Hawaii State Legislature.
State contribution per prescription - additional	Additional State contribution per prescription once program is underway to pass on savings to recipients.
PBM cost per claim adjudicated	Cost per claim to be paid to the PBM.
State Contribution - Admin	State contribution of $1.5M appropriated by the 2002 Hawaii State Legislature in FY 03. In FY 05, reimbursed $1.5M back to the general fund as specified by the legislation.
Federal Contribution - Admin	Federal contribution for the administrative portion at half of the total administrative expenditures.
Drug Rebates	The expected drug rebates from the manufacturers on a quarterly basis. There will be a 6 month lag from the end of the quarter to the collection of the rebates. Calculated as 15% of the total cost for the prescriptions.
State Contribution	State contribution calculated as the State contribution per prescription multiplied by the number of prescriptions.
State Contribution - Additional	Additional State contribution calculated as the additional State contribution per prescription multiplied by the number of prescriptions.
Enrollment Clerks	There will be 6 enrollment clerks. This position is equivalent to the State salary level SR 11. For each year, estimated base increase of 5% based on increases experienced in most recent year.
Supervisor	This position is equivalent to the State salary level SR 24. For each year, estimated base increase of 5% based on increases experienced in most recent year.
Clerk Typist	This position is equivalent to the State salary level SR 8. For each year, estimated base increase of 5% based on increases experienced in most recent year.

Item	Description
Fringe Benefit	Fringe benefits for the State are at 32.22%.
Consulting/Programming	Cost for programming front-end eligibility system, building interfaces to existing enrollment system, and developing data files for the PBM.
Temp FTEs for start-up	Temporary FTEs at $16 per hour needed for assistance with processing applications (14 temps for FY 04, 4 temps for FY 05, 1 temp for FY 06-08).
Telephone Installation	Installation of phone lines at $500 per line. Includes cost of phone for $350 each.
Telephone Ongoing	Monthly phone charges for the phone lines at $30 per line. Rate based on State contract.
Lease Rental	Space requirements at 2,500 square feet at $3/square foot per month for the 8 permanent FTEs. For the 14 temps in FY 04, expect that 7 could be accommodated in existing space and 7 would require 2,200 square feet to be leased.
Desktop Computer	Costs for 2 printers, 22 workstations, and networking printers. Cost for workstations (including monitor) was estimated at $2,200 per workstation. Cost for a printer was based on cost for a LaserJet HP4000TN at $1,200. Cost for networking/lines estimated at $5,000.
Modular Furniture	For 15 cubicles (8 for permanent FTEs and 7 for temps) at $3,000 per cubicle. Includes electrical wiring and setup/assembly.
Supplies	Estimated based on current supply costs.
Postage	Estimated at 2 mailings per recipient per year. One mailing for the ID card and welcome letter and one mailing for the recertification notice at the end of the year.
ACS Claim Cost	Administrative fee paid to ACS for PBM services. Calculated as the cost per adjudicated claim multiplied by the number of prescriptions.
Fax	Estimated fax lease cost per month.
Copier	Estimated copier lease cost per month.

VI. EXPENDITURE AUTHORITY

The Following Authority is Needed for this Demonstration Under Costs not Otherwise Matchable (item is checked to verify the request):

A. __ Section 1115(a)(1) authority of the Social Security Act is requested to enable the state to restrict freedom of choice of provider through a method such as pharmacy benefit management.

B. _X_ Section 1115(a)(2) authority of the Social Security Act is requested for the following expenditures to be made under the Prescription Plus demonstration (which are not otherwise included as expenditures under section 1903) for the period of the demonstration to be regarded as expenditures under the Title XIX program.

> Expenditures for extending pharmacy benefits to qualified individuals at or below 300 percent of the federal poverty level (FPL).

In addition, the following will not be applicable in this demonstration:

- *Premiums and Cost Sharing under Section 1916*: To permit cost sharing that is more than nominal, to be imposed on and collected from demonstration participants.

- *Amount Duration and Scope of Services under Section 1902(a)(10)(B) and 42 C.F.R. Sections 440.230-250:* To permit the state to offer demonstration participants benefits that are not equal in amount, duration and scope to traditional Medicaid beneficiaries.

- *Payment under Medicaid for Eligibility in Excess of Stated Maximums under Sections 1902(a)(1), 1903(f) and 42 C.F.R. Sections 435.100:* To permit expansion of eligibility to non-categorical individuals with incomes up to 300% of FPL.

- *Retroactive Eligibility under Section 1902(a)(34):* To permit the state not to offer demonstration participants retroactive eligibility.

- *Taking into Account Income or Resources under Sections 1902(a)(17), 1902(a)(10)(A)(ii)(I) and (II), and C.F.R. Part 435, Subparts G, H, and I:* To permit the state to not subject individuals to resource (asset) limits when determining eligibility.

- *Freedom of Choice under Section 1902(a)(23) and 42 C.F.R. Section 431.51:* To permit the state to restrict participants to utilizing Medicaid participating retail pharmacies within the state.

VII. EVALUATION

The purpose of Pharmacy Plus is to expand coverage of a prescription drug benefit to qualified Medicare individuals , and, by so doing, to divert or defer entry by these individuals into the Medicaid program. Budget neutrality is a feature of these demonstrations and is designed to track the overall cost and savings of the program. However, it is important to evaluate these demonstrations in other than budgetary terms. To understand how effective the program is for individuals, provide a description below of the state context of the program, the goals for the program, and how the program's success will be evaluated. In addition, CMS intends to conduct an independent evaluation of several of the Pharmacy Plus demonstration projects.

Included as an Attachment to the Application are the following:

A. _X_ Current State Context. Provide an assessment of the current pharmacy coverage status of individuals in the state which includes summary information of individuals whose incomes are at or below 300 percent FPL who:

1. _X_ do not have private insurance or other coverage of pharmaceuticals. Refer to Attachment 3.

2. _____ have private insurance that covers pharmaceuticals

3. _____ are in the state only funded pharmacy program

B. _X_ The state's goal for increasing pharmacy coverage to the population targeted by the demonstration, including:

1. _X__ the state's demonstration hypothesis. Refer to Attachment 4.
2. _____ the state's execution of the hypotheses via the demonstration project operation

VIII. ADDITIONAL REQUIREMENTS

In addition to the above requirements, the state agrees to the Pharmacy Plus Model Special Terms and Conditions (STCs) of Approval, and agrees to prepare the Operational Protocol document as described in the Model STCs. During CMS's review and consideration of this demonstration request, using the Model STCs, we will work with CMS to develop STCs that are specific to this request that would become part of the approval of demonstration authority.

This demonstration proposal is submitted to CMS on ___-___-___.

January 13, 2003
Date

Patricia Murakami, Acting Director
Name of Authorizing Official, Typed

_____
Name of Authorizing Official, Signed

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 1

Public Notice (Assurance D Description)

The Department of Human Services, Med-QUEST Division (MQD) will satisfy the Federal requirement for public notice through publishing an informational notice about the program including how to apply in the newspaper of widest circulation in the State. MQD may decide that publishing the notice in the three newspapers (i.e., Honolulu Star Bulletin, Honolulu Advertiser and MidWeek) may be desirable.

MQD also plans to convene a group of key stakeholders to assist with communicating to potential recipients about the program, its benefits and how to enroll. These stakeholders include AARP, labor unions, retail pharmacies, sponsoring legislators, potential recipients and physicians. MQD will work with this group to provide education about the demonstration program, coordinate communications and make sure that the messages clearly and accurately describe the program. The stakeholder groups such as AARP and the labor unions have an existing infrastructure for reaching out to their membership and have offered their assistance to MQD.

PHARMACY PLUS
A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 2

DEFINITIONS

Budget Neutrality –The policy for Section 1115 demonstrations under which the federal costs of services provided during the demonstration will be no more than the expected federal cost to provide Medicaid services without the demonstration.

Budget Neutrality Ceiling –An expenditure limit, negotiated between the state and CMS, placed on the amount of FFP available to a state under the demonstration. The expenditure limit for Pharmacy Plus waivers is calculated using the aggregate method. The aggregate expenditure limit is calculated as a fixed amount that does not vary based upon enrollment changes in the state.

Private Health Insurance - Group health plan coverage and health insurance coverage as defined in section 2791 of the Public Health Services Act.

Expansion population - Individuals eligible for benefits under the state Pharmacy Plus demonstration program who are not enrolled in the regular Medicaid program.

Traditional Medicaid benefit – The Medicaid benefit package available to individuals who are eligible under the State Plan for Medicaid without the Pharmacy Plus waiver.

Impacted population - The Medicaid eligibility group or groups whose Medicaid costs are included in the budget neutrality cap. Under Pharmacy Plus, the state is expected to achieve savings from this group because of the diversion from the regular Medicaid program of a proportion of the expansion population.

Enrollee Cost Sharing – Premium charges, enrollment fees, deductibles, coinsurance, copayments or other similar fees that the Pharmacy Plus enrollee is responsible for paying. Cost sharing for Pharmacy Plus enrollees can deviate from requirements in Medicaid and can be used to reduce program costs by requiring participant payments, encouraging the use of non-brand drugs, and can vary to moderate out of pocket burdens for high utilizers.

Enrollment Ceiling -- A number limit on demonstration program enrollment. States may use an enrollment ceiling to limit the numbers of individuals enrolled in the demonstration so that financial risk for demonstration costs is minimized. States may not enact an enrollment ceiling for the non-demonstration Medicaid program.

Drug Rebates - The quarterly payments made by the pharmaceutical manufacturer to the state

Medicaid agency, as calculated in accordance with section 1927 of the Social Security Act and the provisions of the agreement between the manufacturer and the Secretary. States can receive rebates for pharmaceutical products in Pharmacy Plus as long as a state payment is made for the drug.

Wraparound Coverage - Pharmacy Plus coverage of services not covered under a beneficiary's private health insurance. Examples of wraparound coverage include a Pharmacy Plus program paying for drugs not covered by private insurance, a Pharmacy Plus program covering an amount of drugs in excess of that covered by private insurance (for example, if the private insurance coverage includes three prescriptions per month, Pharmacy Plus could pay for additional prescriptions); and Pharmacy Plus coverage when a private insurance financial benefit is exceeded.

Terms and Conditions of Approval - A document produced by CMS which provides conditions which states must follow in order to receive approval of their Pharmacy Plus waiver.

Operational Protocol - A stand-alone document that reflects the operating policies and administrative guidelines of the Pharmacy Plus waiver.

Prior Authorization – Requiring approval of the drug before it is dispensed as defined in 1927(k)(6) of the Act.

Formulary or Formulary Exclusions - A list of prescription drugs developed in accordance with 1927(d)(4) of the Social Security Act. At state option, the formulary provisions for the expansion population may differ from 1927(d)(4) as delineated by the template allowance of coverage of condition-specific drugs or limited sets of drugs (see template).

PHARMACY PLUS

A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 3

Current State Context

The total population of Hawaii was 1,213,000 in 2001 based on U.S. government census data. There are an estimated 205,800 individuals in Hawaii who do not have private insurance or other coverage of pharmaceuticals. The breakdown is as follows:

- 117,000 people were not covered by health insurance in 2001, based on U.S. government census data.
- It is estimated that 88,800 people had private health insurance with no drug coverage. This is based on U.S. government census data, which reflects that there are 888,000 individuals in Hawaii who have private health insurance. Of these 888,000, an estimated 10% do not have pharmaceutical benefits. The figure of 10% was provided to the State legislature in 2001 by the two largest health plans, Kaiser and Hawaii Medical Service Association, which cover 60% of Hawaii's residents.

Of the estimated 205,800 individuals with no private or other coverage of pharmaceuticals, an estimated 149,500 individuals would qualify for the demonstration program as of 2001. This estimate was arrived at using the following assumptions and estimating methodologies:

- It was assumed that all of the 117,000 people not covered by health insurance would qualify for the demonstration program. Employer sponsored health insurance is mandatory in Hawaii and therefore employed individuals working more than 20 hours a week would have access to health insurance through their employer. The uninsured group would include the unemployed, students, self employed that cannot afford health insurance, individuals working less than 20 hours per week and others that may not qualify for Medicaid and cannot afford health insurance premiums. It is very likely that these individuals will have incomes below the 300% FPL.
- It is estimated that 32,500 people that have private health insurance with no drug coverage would qualify for the demonstration program. This amount was derived by applying the percentage of Hawaii's population that fell within 100% and 300% of FPL. The percentage was obtained from the U.S. government census data on household incomes for 2000.

The demonstration program is projected to begin in FY 04. By applying the forecasted population growth of 1% per year to the 149,500 for 3 years, the estimated number of annual demonstration recipients is 154,100. At the end of the 5 year demonstration period, the estimated number of recipients is 159,600.

PHARMACY PLUS
A DEMONSTRATION PROGRAM UNDER SECTION 1115

Attachment 4

Demonstration Hypothesis

Prescription drugs have become a more important and more costly element of health care. Over the past several years, prescription drug costs have continued to rise and become unaffordable for the uninsured or the underinsured who are most likely to be the working poor, the unemployed, the elderly, disabled or individuals on fixed incomes. These individuals incur significant out of pocket costs for prescription drugs, often paying two or three times the amount paid by an insured person buying the same prescription drug. The uninsured or underinsured are cash customers who are forced to pay the full retail cost of prescription drugs, thereby incurring significant out-of-pocket costs or opting to forego needed medications. In addition, the number of drugs prescribed by physicians has increased. This increased utilization is due to the availability of newer and more advanced drugs. These prescription drugs are usually costlier and as a result, an increased number of patients now receive more expensive drug treatments than in previous years.

Individuals who lack prescription drug coverage tend to fill fewer prescriptions than those with coverage. Lack of coverage for prescription drugs translates into reduced access to needed medications. In addition, access has also been threatened even further by reductions in private prescription drug coverage and benefits and, therefore, is not limited to low-income individuals.

The appropriate use of prescription drugs for significant medical conditions such as hypertension reduces the risk of heart attack, heart failure, stroke, and kidney failure. In such clinical areas, evidence shows the drugs' value in reducing other medical spending and improving the quality of life. In addition, reduced prescription drug usage is associated with higher nursing home admissions, more frequent hospitalizations and greater use of emergency room mental health services.

This program seeks to provide broader access to discounted drug prices to an expanded population. The demonstration hopes to determine whether providing expanded access to prescription drugs will lower the overall cost of medical care by decreasing nursing home admissions, acute care episodes, and emergency room visits and increase the quality of life by providing safe and quick treatment to avoid hospitalization and more invasive procedures.